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ABSTRACT

Presented are evaluations of eight 1973-75 objectives of the Oregon Model Center for children with learning disabilities. The center was developed to facilitate expansion of the Educational Evaluation Center, a diagnostic-prescriptive center at Oregon College of Education. Among objectives evaluated are: studying the process of the Education Evaluation Center to develop more efficient and effective methods of diagnosing and prescribing for learning disabled children; developing minidemonstrations of methods and materials to be delivered with the prescription for the child; and developing a training program for administrators of Diagnostic-Prescriptive centers. Included is information such as suggestions from advisory councils regarding changes in the diagnostic-prescriptive process; results of followup studies in which teachers and parents were surveyed; descriptions of materials produced for parents and teachers; contents of a diagnostic-prescriptive manual; and evaluations of the three pilot centers established. Appendixes include parent and teacher followup forms and the diagnostic-prescriptive service program report from a local school district. (LS)

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Program for Children with Specific Learning Disabilities
P.L. 91-230 Title VI-G
Final Report on Products and Activities of the
Oregon Model Center, 1973-75

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
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Grant No. OEG-0 73-2852

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Project Director Thomas D. Rowland

Evaluation Report Submitted by Abigail B. Calkin

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Introduction

The Educational Evaluation Center is a diagnostic-prescriptive center located on the campus of Oregon College of Education in Monmouth, Oregon. The philosophy of the center is based on the assumption that the Learning Disabled child and his total intrinsic and extrinsic environment comprise a system. A learning disability is viewed as the malfunctioning of one or more of these systems. Services provided for Learning Disabled Children in Oregon are supplementary to regular instruction and are usually provided by itinerant certified specialists.

The demands for the services of the Education Evaluation Center have greatly increased during the past years. In 1962-63 there were 80 children referred, in 1974-75 there were 330 referred. This demand made it imperative that local Diagnostic-Prescriptive that local Diagnostic-Prescriptive Centers be established. These local centers were to be designed to utilize the resources of personnel throughout the state and the resources of the ASE1MC's which had already been established.

In order to facilitate this needed expansion of the Educational Evaluation Center and its concepts and practices, the Oregon Model Center was developed and funded for the fiscal years of 1973-75.

In designing the Oregon Model Center eight objectives were stated. Each of the objectives is listed below, their status summarized in Table 1, page 4, and their evaluation

discussed beginning on page 7.

This report notes the changes made from the original grant. It also summarizes and evaluates each of the objectives listed in the revised 1974-75 grant. The evaluation of each objective is discussed with each objective rather than at the end of the report.

Program Activities

The Objectives

1. To study the process of the Education Evaluation Center to develop more efficient and effective methods of diagnosing and prescribing for learning disabled children.

2. To make more effective the delivery of the prescription by examining what happens following the recommendations which has implications for changes in the delivery system.

3. To develop mini-demonstrations of methods and materials to be delivered with the prescription for the child.

4. To develop an "Administrators Manual - Learning Disabilities Diagnostic Center".

5. To develop a Differential Diagnostic and Prescription Manual.

6. To establish at least two pilot centers in 1974-75.

7. To develop a training program for administrators of D P Centers.

8. To develop a training program for clinicians in D P Centers.

9. To conduct an evaluation of the effectiveness of the manuals, mini-demonstration packages, the training programs and pilot centers.

Table I gives a summary of the major parts and the present status of each objective.

Table I

Status of Center Objectives

June 15, 1975

	Completed	Partially Completed	Not Completed	
1. To study the process of the Center				
1.1 Refine diagnostic procedures	X			
1.2 Compare of OCE MC, and 3 pilot	X			
1.3 Number of children referred	X			
1.4 Refine process	X			
2. To make more effective the delivery system				
2.1 Follow-up in 74-75	X			
3. Develop mini-demonstrations of methods and materials				
3.1 Develop Materials	X			
3.2 Develop Video tapes	X			
3.3 Determine if workshops produced materials requests	X			
4. Develop Administrative Manual			X	Completed- 72% Partially Comp. 16% Not Completed 12%
5. Develop Diagnostic-Prescriptive Manual		X		
5.1 Assemble and develop materials	X			
6. Establish a Pilot Center	X			
6.1 The Pilot Centers				
6.10 Number of Children referred	X			
6.11 Follow model of Model Center	X			
6.12 Reach parents	X			
6.13 Reach teachers	X			
6.14 Visit Pilot Centers	X			
6.2 Establish Additional Centers for 75-76	X			
7. Retrain professionals to establish Administrator Centers				
7.1 Retrain professionals		X		
7.2 Hold workshops		X		
8. Retrain D-P Professionals		X		
9. To evaluate the				
9.1 The effectiveness of the manuals			X	
9.2 The mini-demonstration packages			X	
9.3 The Training Programs	X			
9.4 The Pilot Centers	X			

Changes

The major changes from the original grant involves the evaluation of the project goals and objectives, the evaluation of materials and products suitable for dissemination, the evaluation plans for determining replicability of program components and the evaluation of the training programs.

The evaluation component was not sub-contracted to Teaching Research Division of the Oregon State System of Higher Education as stated in the original grant. This change was made on the advice of the staff at the Leadership Training Institute who felt that $13,500 was much too high an allowance for evaluation. The request for approval of that change had been submitted and approved by Ms. Becky Calkins on January 1, 1974. An Information Resources Assistant who was a Learning Disabilities Specialist in the training staff at O.C.E. was hired to do the evaluation.

The length of time for training programs was shortened from its original 8 weeks. It was more realistic to allow a two week training program for teachers of the learning disabled and a one week training program for administrators of diagnostic-prescriptive centers with follow-up visits to the Pilot[1] Centers during the year.

In the second year of the project the ability of the Pilot Centers to function on behalf of children with learning disabilities was also evaluated primarily in the areas of their

[1] The term 'Pilot Centers' refers to the pilot satellite centers functioning during the 1974-75 year. The term 'Satellite Center' refers to the 11 satellite centers established during the spring of 1975, to be functioning during the 1975-76 year.

liaison with the Oregon Model Center and the training programs.

The original date of completion for the Diagnostic-Prescriptive Manual, and the Administrators Manual was changed from June 1974 to June 1975. The reason for this change resulted from the commitment to the Pilot Centers. This commitment and the need to communicate with the Pilot Centers was much greater than anticipated. Since the Director and the Associate Director were one quarter time much of the time that would have gone to the Manuals in 1973-74 was devoted to the Pilot Centers.

The completion date for the mini-demonstrations was also changed from June 1974 to June 1975. During the 1973-74 year there was no staff sufficiently skilled in educational media to produce the necessary materials. During 1974-75 a media specialist was hired specifically to do the production. The money for this salary was provided by monies carried over from the 1973-74 year.

Another revision affected the Advisory Council for the 1974-75 year. This Council was to include staff from each of the 11 Satellite Centers. However, since these 11 Satellite Centers were not identified until March 1975, their participation in the 1974-75 Advisory Council was not possible. The Director has met with each of the 11 directors of the Satellite Centers to discuss their needs but there has been no formal meeting with all 11 present.

Objective 1. To study the process of the Education Evaluation Center to develop more efficient and effective methods of diagnosing and prescribing for learning disabled children.

The Oregon Model Center is an evaluation center for the state of Oregon for children with learning disabilities other than mental retardation. Referrals are accepted from public and private schools and from physicians. No child is excluded from referral if a significant learning disability exists. If the public or private agency identifies a child with an extreme learning problem they have only to communicate with one of the above. The Center does a complete pyschological and educational evaluation and provides written reports with recommendations for some remedial course to the referring agency and to the parents of the child.

Evaluation

Process

The following processes presently are included in the assessment of each child.

1. Receiving the referral
2. Gathering previous data
   a. School
   b. Medical
   c. Other
3. Making an appointment

4. Conducting the Assessment
   a. Historical
   b. Sensory
   c. Speech and Language
   d. Psychological
   e. Educational

   The child is assessed in the following areas:
   a. Mental Ability
   b. Oral Speech Function
   c. Oral Language
   d. Sensory Functioning
   e. Perceptual Functioning
   f. Motor Functioning
   g. Environmental Variables
   h. Personality
   i. Physical Health
   j. Academic Skills
   k. Motivation and Interest

5. Staffing

6. Conferencing
   a. Parent
   b. School personnel
   c. Others as necessary

7. Written Report
   a. Parent
   b. School
   c. Others as necessary

8. Follow up
   a. Parent
   b. School Personnel

Revisions

Many recommendations have been made to the Model Center during the past year from the Advisory Councils, teachers and others. Each suggestion and the action taken by the Center follows:

1. Prior to the inception of the Oregon Model Center, the Educational Evaluation Center relied on graduate students for audiometric testing. They

now have the services of a fully qualified speech and hearing therapist who assesses every facet of expressive and receptive language functioning.

2. The following forms have been revised, printed and are in use:

a. referral form (two revisions)
b. medical information form - release of medical information and physicians information letter
c. teachers follow-up questionnaire form (two revisions)
d. parent follow-up questionnaire form (two revisions)
e. history form

3. The physicians revised checklist for medical problems also includes an opportunity for narrative report. They are given the opportunity to make a more specific statement about what is seen as the specfic learning disability.

4. More specific recommendations were needed regarding the methods, materials and the psychological climate. The clinic is now more sensitive about making specific and positive recommendations about methods, techniques, materials and/or behavior management programs. Information about materials and specific techniques or methods are now available as a result of Objective 2, the development of video and audio tapes and booklets and of Ocjective 5, the Diagnostic-Prescriptive Manual.

5. Suggestions from Council I

A. The parents now receive a copy of the same report given to the physician and/or the teacher and they also designate to whom they want the report sent.

B. The Center prepared literature for parents about

Learning Disabilities and recommended various resources to parents as well as the referring agency and teachers.

C. Based on a need stated by the parents for the education of professional persons about learning disabilities, the Center is preparing training materials as an ongoing process.

D. Parents wish a check list of symptoms which would help them identify children's problems. This is being considered by the staff.

E. A brochure was developed and sent to families before their clinic appointment. The brochure included pictures, description of the evaluation process, a print tour and a map showing the location of the center. This brochure was revised a second time in 1974-75.

F. In order to gain information from the child as well as the parent, the EEC does informal information gathering with the child.

G. To give teachers and principals information on the Center, brochures are sent to the schools. A statement of philosophy is included.

H. Teachers and/or principals may request to observe the testing through 2 way mirrors. Teachers are encouraged to come to the center to aid in the diagnosis as well as the recommendations.

I. Two children are scheduled for testing at the same time. This seems to make each of the children more confortable in the testing situation.

J. The Center now gives the child the results of the tests showing ranking in math, reading, etc. These results are usually shared with the child at the time of testing.

K. There were at least four recommendations made by the Council and not followed. The primary reason for this was the impraticality of these suggestions.

6. Comments from Council II

A. They indicated the need not to replicate other manuals, rather to include qualitative as well as quantitative aspects of the child.

B. The process of evaluation should be spelled out. Greater emphasis should be placed on prescriptions and how you derive them from information from the evaluation process. This is being done.

C. Examples or cases should be followed in the manual. This has been taken into consideration and, as well as in the manual, this type of discussion and exercises have been included in the follow up or updating workshops for the teachers.

Comparison of Model Center and Pilot Centers

Evaluation Procedures

A questionnaire was designed to obtain information on the evaluation procedures of the three pilot centers and the Model Center. The director of each center filled out the evaluation procedures questionnaire.

The eleven questions were concerned with the four major areas of the content of the referral procedure and evaluation process, the assessment components, the sharing of information from the evaluation, and the follow-up procedures.

The three pilot centers followed the same basic referral format as the Model Center. This included problem identification, school and parents contact and a completed referral form. The steps in the evaluation process were also the same except that Astoria and Corvallis included the parents in the final staffing on a child. All centers except for Astoria had all the evaluation staff employed within its district. Astoria received outside consultant services from the Mental Health Clinic for the psychological and some educational aspects of the evaluation.

In looking at the assessment components and the approach to evaluation Albany stated it took an etiological and diagnostic approach as does the Model Center. The other two centers stated they used a diagnostic-prescriptive approach. All four centers stated they looked for both the strengths and weaknesses of the children.

All centers have included the gathering of etiological, sensory, psychological, speech and language, and educational data in their assessment. However, the only specific testing to be done by each of the pilot centers which was identical was the portions of the educational assessment which included the use of the Wide Range Achievement Test and the daily gathering of data for plotting the celerations of each child. These data were gathered for the purpose of measuring the progress of each child evaluated by each of the pilot centers. This will be discussed further under Objective 6.

In all instances the evaluation report was shared with the parents as well as the schools. As previously stated, two of the Pilot Centers included the parents in the school staffing following the write-up of the evaluation results.

Follow-up was done with the parents and teachers by all four centers although a follow-up was not always done with each child. The Model Center and Corvallis did follow-up by telephone. Albany centered its follow-up emphasis in the schools and Astoria followed-up with follow-up forms, visits, phone calls, and written reports. Corvallis stated an intent to continue using the probe sheets next year as part of their 75-76 follow-up procedures.

Evaluation Forms Used

Each of the three pilot centers and the Model Center used a set of forms in their evaluation process. The forms were

understandably close in format since the pilot centers designed their forms after the Model Center's forms. Table II shows which forms were the same and which were different.

Other programs established

Corvallis

Corvallis has had a parent training program in operation since 1958, 15 years prior to the inception of the Pilot Center there. Each parent is referred to these parent training sessions if appropriate.

Corvallis also developed a form for listing the recommendations of the staffing. This form was given to the teacher and to the parents.

Albany

Albany had a prescription sheet and a daily instruction plan sheet, each of which was filled out by the ELP specialist concerned and used by the classroom teacher. The behavioral orientation of these two forms was most probably a result of the strong behavioral aspects of other programs within that district.

Astoria

The additional forms from Astoria all related to follow-up. Astoria did both parent and teacher follow-up during the year as well as a recommendation review. The teacher filled out the recommendation review in terms of which of the evaluation report recommendations she had used and not used as well

as how well the recommendations that were used worked.

The results of Astoria's follow-up are discussed on page 37 .

Table II

Forms Used by Oregon Model Center

and by the Three Pilot Centers

	Monmouth	Albany	Astoria	Corvallis
Flyer describing program	X	X Adapted	X Adapted	X Adapted
School Referral Form	X	X Identical	X Identical	X Identical
Information Release Permission	X	X Identical	X Original	X Original
Case History	X	X Adapted	X Identical	X Adapted
Medical Release	X	X Identical	X Identical	X Identical
M.D. Information Form	X	X Identical	X Identical	X Identical
Audiometric Form	X	X Identical	X Identical	X Identical
Other	1) Parent follow-up 2) Teacher follow-up	1)Sensory screening reports 2)Reading Profile 3)Prescription sheets 4) Follow-up forms	1) Parent follow-up 2) Teacher follow-up 3) Recommendation review 4) Conference form	1) Parent Training 2) Staffing recommendation form for teachers and parents

Population Served

The number of children evaluated by each center is listed in Table III. The 73-74 evaluations in Astoria were done under Title I funds and served as a needs assessment for a Pilot Center in Astoria. The school personnel and parents served includes the number of persons contacted, not the number of contacts made. The school personnel category includes classroom teachers, ELP teachers, counselors, and administrators.

Table III
Population Served
September 1, 1973 through June 15, 1975

	Children Evaluated			School Personnel	Parent	College Student
	Staff	Practicum	Stud.			
ECE/MC @ OCE						
1973-74	130	52		100*	182	45
1974-75	129	96		81	235	44
Pilot Center @ Albany	4			8	4	1
Pilot Center @ Corvalls	7			16	13	5
Pilot Center @ Astoria						
1973-74	11			11	11	0
1974-75	20			40	31	0

*Estimate

Objective 2. To make more effective the delivery of the prescription by examining what happens following the recommendations which has implications for changes in the delivery system.

In order to determine the effectiveness of the recommendations, follow-up was done with the teachers and with the parents. The purpose of the follow-up was twofold: 1) to feedback into the system changes needed in the Center's operation, and 2) to supply further information to help the child.

Staff members and OCE graduate practicum students did the Model Center follow-up studies by phone and by mail. There were two forms designed by staff members, one for parents and one for teachers.

1973-1974 Follow-up

In the spring of 1974 the staff conducted a follow-up on 100 of the children evaluated during the 1973-74 school year.

The Center conducted all follow-up by telephone and there were an additional 70 phone calls which were second or third follow-up on those same 100 school personnel. Personnel contacted included classroom teachers, ELP teachers, principals and counselors. There was no follow-up reported on parents.

The results indicated that 25% of the changes made by teachers in methods, materials, and psychological climate were made after the first follow-up call, approximately three months after the child had been evaluated. Results also

showed that over half the teachers reported change in giving more one-to-one assistance to a child, trying new methods and materials, and increasing their use of positive reinforcement. In conjunction with this over half the change teachers noted in the children was in academic performance and grades, and in an improved self-concept and better attitude towards school.

The results of this follow-up indicated that more specific recommendations were needed; that the source of materials recommended should be stated; and that detailed explanations of the prescribed methods and materials should be supplied in written form, cassette or video tape. Each of these suggestions was incorporated during the 1974-1975 year.

1974-1975 Follow-up

The Center received 49 follow-up evaluations from the 65 teachers contacted of the 116 children who were seen at the Education Evaluation Center from September 1974 through February 1975. The teachers completed the detailed, open-ended evaluation form shown in Appendix A.

Teacher Follow-up

Of the teachers responding 46 indicated that they had received and read a copy of the report from the Center. The other three teachers did not include this information. Thirty-two teachers commented about the report itself. Most frequently, the teachers felt that the report was thorough and helpful.

Twenty-eight teachers indicated that the report included new information about the child; eight said that the report confirmed what they believed about the child; and six felt no new information about the child was given in the report. New information was given in the following areas:

-mental ability (greater than indicated by placement in school)
-home environment
-specific areas of difficulty, including academics, hearing and vision
-attitudes toward school
-specific test results
-information that indicated a behavior problem that was not exhibited at school
-detection of a hearing loss

Forty-two teachers implemented at least some of the recommendations included in the report. The teachers specifically reported that 23 behavioral-social recommendations were implemented. Recommendations used included the following categories:

-placed in higher academic group
-gave more praise
-ignored undesirable behavior
-implemented reward system; contract system
-allowed child to help others; gave more responsibility
-gave better explanations, directions
-implemented personalized reading program:whole word, impress, use of reading cards, etc.
-checked work more frequently
-implemented one-to-one working relationship
-set specific goals
-limited assignments to insure success

Of the 42 teachers who implemented the recommendations, 37 observed changes in the academic and/or behavioral-social changes in the child. Thirty-three indicated that the

that the changes were positive; four felt the changes were positive but not maintained; and seven observed no changes in the child. The reported changes included progress in work habits, increased enthusiasm for reading, and better work in most academic areas; better social relationships, making progress in controlling undesirable behaviors, longer attention span, better feeling of accomplishment; more self confidence and the child appearing happier. Fourteen teachers reported that at least some of the suggested recommendations were not implemented. The most frequent reason given was lack of teacher time or personnel to implement the recommendations.

Only four teachers stated that recommendations were implemented but found not to be helpful. One teacher indicated specifically that the Michigan Tracking System was not helpful. Nine teachers reported that recommendations were not implemented because the materials or methods suggested were unavailable or unfamiliar.

Sixteen teachers indicated that formal tests have been given to evaluate academic growth since the child was seen at the Center. Eight teachers indicated that growth was exhibited; seven teachers stated that the results were not yet available; and one indicated no growth. Four teachers indicated that informal tests were given to determine academic growth, and that growth was exhibited in each testing situation.

Thirty-one teachers perceived that the report was helpful to the child's parents. Seven teachers felt that they had no evidence to indicate that the report was helpful to the child's parents; two felt the report was not helpful; and three did not know. Eight teachers did not respond to the question.

Parent Follow-up

Thirty-nine parents of children who were seen at the Education Evaluation Center from September, 1974 through February, 1975 completed a detailed, open-ended evaluation form. Of the parents responding, 38 indicated that they had received a copy of the report from the Center. The one who indicated they had not yet received a copy was immediately sent one.

Twenty-six parents commented the report itself was complete and helpful. Twenty parents indicated the report included new insights or information for them about their child. Eight more reported that the report confirmed previously held ideas about their child and five felt they gained no new information.

Thirty-six parents implemented at least some of the recommendations included in the report. The parents specifically reported that 17 behavioral-social recommendations were implemented. The remainder were academic or had aspects of both academic and behavior. Recommendations were in the following categories; time-out for unacceptable behavior, additional privileges, extra time with parents, allowing the child to do more for himself, increasing vocabulary in family

conversation, encouraging him to bring home books, and implementing a point system. Of the 36 parents who implemented the recommendations, 33 observed changes in the academic and/or behavioral-social area in the child. Thirty-two indicated that the changes were positive and one negative. Three parents reported no change. The reported changes included increased time spent reading at home, less tension in the family, child responding well to praise, increased self-confidence with peers, and better adjustment in school. Only five parents stated that recommendations were implemented and were not found to be helpful.

Twenty-two parents perceived that the report was helpful to the child's teacher. Eight felt it resulted in no change at school for the child and four felt they did not have evidence either way. Three parents used this space to relate conditions in their child's class and ask, both directly and implicitly, that the Center act as intervening agent to help change the child's situation.

Seventeen parents had further questions or recommendations as a result of the child's evaluation at the Center. They included the following:

-"wish you could make school and home visits to see how things are going"
-"would like to see OCE sponsor a parent education program."
-"would like further help with his reading. Further recommendations and ideas for help over the summer months."
-"make Center more widely known to both parents and teachers who need help".

Table IV

Follow-up Summary

	Teachers(73-74)	Teachers(74-75)	Parents (74-75)
Sent follow-up information	100	49	39
Received report	92%	94%	97.5%
New information given	*	57%	51%
Old information confirmed	*	16%	20.5%
No new information given	*	12.5%	13%
Implemented some recommendations	*	86%	92.5%
Noted behavior & academic changes	76%	88%	92%
Noted no change or change not maintained	51.5%	26%	8.5%
Not helpful or not implemented	43%	31%	14%
Gains seen	*	50%	NA
Perceived report as helpful to other party	62%	63%	61%

*Information not available

A comparison of the 1973-74 follow-up with the 1974-75 follow-up indicated that the suggestions from the 1973-74 year were used during the 1974-75 year. As shown in Table IV the information gathered during the second year was more complete-- parents were followed up and the value of the information was assessed. A comparison of the follow-up for each year indicates that more recommendations were used and more academic and behavior changes were noted in the children evaluated during the 1974-75 year.

Objective 3. To develop mini-demonstrations of methods and materials to be delivered with the prescription for the child.

The development of materials has served a dual purpose. When a recommendation is made, the clinician writing the report can use the materials list as a guide for the materials to recommend. Secondly, the materials are readily available to loan to the teacher receiving the report.

The evaluation of the mini-demonstration packages was not done since the materials were not available for dissemination until June 1975.

Materials Produced

The materials developed have included video tapes, audio tapes, booklets, and bibliographies of published materials.

Video Tapes

The 22 video tapes were designed for teachers and were demonstrations of specific special education materials, techniques, and methods applicable to teaching the learning disabled child.

All tapes made were cassette, some in black and white, others in color. Copies of each tape will be available to loan to any teacher to demonstrate a specific teaching technique or material suggested in the recommendations. The following list divides the tapes into three major categories and gives the title, color, and approximate length of each tape.

	Color	B&W	Approx. Time
1. Explanation of materials			
Michigan Tracking System	X		20 min
Whole Word Method	X		15-20 min
Reading for Understanding SRA	X		20-30 min
Kottmeyer Reading Program	X		20 min
Behavior Modification		X	1 hr
Barnell Loft Reading Materials	X		
Precision Teaching		X	20 min
2. Explanation of Materials and a Demonstration with Students			
Auditory Blending		X	0-50
Sullivan Materials	X		30 min
Engelmann Becker Materials	X		15 min
VAKT Methods	X		10 min
The Blue and Red Mouse-Lang. Exp.		X	20 min
Distar Reading	X		1 hr.
3. Clinic Examples			
Margaret - student example		X	1 hr.
Margaret's Parents-interview		X	1 hr.
Bill Poorman Interview (mirror vision)	X		25 min
Behavior Management Problem-demon.	X		5-10
Word Calling	X		5 min
Reading Difficulties-interview with H.S. student	X		20-25 min
Block Design Difficulties	X		5 min
Missy		X	1 hr
Tutoring L.D. Children		X	20 min.

Audio Tapes

Three of the audio tapes are for parents, one is for teachers and one is for parents or teachers. The three designed for parents were made with the realization that not all parents read well enough to read the booklet produced. These three tapes are a reading of each of the booklets.

The audio cassette designed for teachers was a discussion of the purpose of testing and how it affects the way in which a test is administered and interpreted. The final tape is the audio portion of one of the video tapes.

Helping Your Child Read at Home Contingency Contracting with the Child Resistant to Authority Teaching Your Child to be Independent	for parents
Comments on the Gates-McKillop Test	for teachers
Bill Poorman Interview	for parents or teachers

Booklets

Four booklets were completed. These are very short, easily read how-to-do-it books. More booklets were proposed but did not reach fruition. The four booklets are:

Helping Your Child Read at Home Contingency Contracting with the Child Resistant to Authority Teaching Your Child to be Independent	for parents
Color It Pink	for teachers

Helping Your Child Read at Home and Color it Pink were both completed during the 73-74 fiscal year. The other two booklets, although written, were not printed at the time of this writing due to the lack of any illustrative materials

for them. The illustrations in the first two booklets received sufficient positive comments to warrant waiting to publish the other three until illustrations were drawn for them. Their projected completion date is July 15, 1975. In addition to these, there are three more booklets in process.

Bibliographies of Published Materials

The bibliographies of published materials are included in the appendices of the Diagnostic Prescriptive Manual.

Requests for Materials

The requests for materials developed has not been extensive since the majority of the materials were developed during the 1974-1975 year. The two materials developed during the 73-74 year did have numerous requests. The requests for Helping Your Child Read at Home totaled 152, for Color It Pink 80. The workshops given by the Model Center and its personnel produced about 50% of these requests, information in the Edugram about 35% and 15% to other miscellaneous sources. Each Pilot Center was given 100 copies.

Objective 4. To develop an "Administrators Manual Learning Disabilities Diagnostic Center,"

The Administrators Manual is presently in its rough draft form. At the present time information has been gathered from the State Board of Education and from the Pilot Centers about what should be in the manual.

The projected completion date for the Manual is August 23rd, 1975 at which time it will be shared with the administrators from the 14 Satellite Centers. First impressions will be gathered at this time and further evaluation will take place during the 1975-76 school year.

Objective 5. To develop a Differential Diagnostic-Prescriptive Manual.

The Diagnostic-Prescriptive Manual is divided into nine chapters and four appendices. The rough draft of the manual is completed and the finished copy will be printed in July 1975. Because the manual is recently finished, no evaluation has occurred yet. The first evaluation of the manual will take place at the August training workshop; first impressions will be gathered at that time. It will be used in the schools during the 75-76 school year and suggestions for revision will be collected. At that point, the Diagnostic Prescriptive Manual will be re-written.

Content of the Manual

I. OMC Perspective This chapter tells what the Oregon Model Center does. It states that the purpose of the manual is to share information, not to train.

II. What We Believe About How Children Learn. The purpose of this chapter is to share how children learn from the Model Center's point of view. Discussed are what things allow children to learn and that there are many approaches which can be taken.

III. The Center. The Oregon Model Center is described from its inception from the Education Evaluation Center. There are descriptions of how a child is referred, a typical schedule for a child's evaluation day, and what the role of each evaluating clinician is.

Also pointed out is that because one center could not serve the whole state, Satellite Centers were set up. Each district that has a Satellite Center should house that center in one place so that when a child is tested he is tested not in his own school but on neutral ground.

IV. Generating Hypotheses. Chapter IV is felt to be critical since its purpose is to generate efficient hypotheses. It discusses how to guess and how to validate or refute those guesses, the function of a team being to provide more hypotheses than a single individual could give. Also mentioned is how to generate hypotheses from the referral form.

V. Psychological Assessment. Psychological assessment includes what the psychologist looks for, what he does, and the kinds of tests give.. A section of this chapter lists the possible meanings test results can have. It also discusses how to write a report.

VI. Educational Assessment. The items looked for in Chapter V are also relevant from an educational point of view. This chapter also examines why the learning problem may have happened initially, what prevents him from learning now, and what is the best method to use with him now. Methodology of learning is discussed in reading, spelling, and math.

VII. Language Assessment. This chapter lists the test and information given as well as the role of the language clinician. It also discusses the importance of language in learning and in reading.

VIII. Writing the Prescription. The materials specialist writes the prescription or if none is available within a district the ELP specialist would write it. This chapter discusses how to generate a prescription from the collected diagnostic data and from the list of materials in the appendices. Again this area is critical.

IX. Validating the Prescription. It is not known whether the work of the evaluation is correct until there is data to validate whether the prescription worked. It cannot be assumed that because experts evaluated a child and worked together that the prescription is correct. This chapter discusses four ways of assessing the validity of the prescription: 1) a follow-up questionnaire for parents and teachers 2) the Daily Behavior Chart for isolated skills or behaviors 3) grade score gains, and 4) rate of acquistion , or percentage gain.

The Appendices include four kinds of bibliographies: a selective bibliography of materials most valuable to parents; a professional bibliography; a bibliotherapy list; and a reading bibliography which includes basal series according to the four major reading methods, and supplementary lists according to grade levels of books on horses, cars, etc. Any of these sheets may be pulled from the Appendix and attached to the prescription of the report.

Objective 6. To establish at least two Pilot Centers in 1974-75.

There were three pilot centers in operation during the 1974-75 year. They were located in Albany, Astoria, and Corvallis.

In order to assess the effectiveness of the pilot centers academic and management behaviors of the children were evaluated. The first was direct measurement of the gains made by the children. These gains were to be measured in two ways on the Standard Daily Behavior Chart (see Appendix B) and on the Wide Range Achievement Test. The second area measured was the subjective comments of the classroom teachers and ELP specialists and the parents as to the effectiveness of the recommendations of the evaluations.

Academic and Management Behavior Gains

Standard Daily Behavior Chart

The Standard Daily Behavior Chart is a six-cycle semi-logarithmic chart which can be used to evaluate academic and management behaviors. Pinpoints ranged from digits written correctly to comprehension questions answered and from talking out to negative behaviors. In addition to showing the daily frequency of each child's behavior, the celeration, or rate of growth can also be shown. According to the data collected on over 32,000 projects by the Precise Behavioral Management System in Kansas, the median celeration is x 1.1 per week, or ÷ 1.1 per week. The Standard Daily Behavior Chart was used in

this evaluation to measure the performance of the children since it gives celeration, it can be used to measure behaviors not measured by standardized tests, and it can measure change over a short period of time.

Behaviors Measured

The behaviors to be measured on each child, chosen by the school psychologist, ELP teacher, or the classroom teacher were pinpointed because they were relevant to that particular child. Each behavior was to be counted for ten days once a month.

Of the thirty-one children evaluated at the Pilot Centers, 10 day counts on 13 children were submitted. On four of these 13 children the counts occurred once a month. On the others there was either one or two counts in a four month time period. There was a total of 25 probes submitted each of which constituted a phase during which a change in the child's behavior was attempted. There were no phases monitoring a behavior.

Results

The results of the charts were evaluated in two ways -- the celerations were computed and each project was examined for a pinpoint change which would indicate pupil progress. These results are reported collectively for all three centers and for each center.

Celeration

The median celeration for all project acceleration phases was 1.3. This indicated that these learning disabled children were making weekly progress on acceleration projects at a rate greater than normal. The celerations for all acceleration projects

are shown in Figure 1.

In computing the celeration for the deceleration projects, 17 of the 23 phases were used. The six projects with a constant error frequency of zero were omitted since these had no opportunity for a celeration change. The median celeration for these 117 projects was ÷ 1.3. Again, this indicated that these disabled children were changing on their deceleration projects at a rate greater than normal. The celerations for all deceleration projects are shown in Figure 2.

Albany. Counts on six academic behaviors of two children and on a management behavior of one child were submitted. The acceleration targets had a median celeration of x 2.1 while the deceleration projects showed a median celeration of ÷ 2.0.

Corvallis. The Corvallis projects on five children were all one and two minute timings on academic behaviors. The 10 acceleration celerations ranged from a ÷ 1.5 to a x 1.6 with a median of x 1.27. The 10 deceleration celerations ranged from ÷ 1.6 to x 1.8. Omitting the five celerations whose frequency was zero, the median celeration was ÷ 1.3. There was one child who showed acceleration on all three of his deceleration phases; in the spring of his second year in first grade, he was just beginning to learn the letter sounds. It is not uncommon for a child when initially learning new material to make as many errors as correct responses.

Additional progress was demonstrated on five acceleration projects by a change to a more difficult pinpoint, e.g., progressing from +1 to +2, from the 2nd to the 3rd grade Dolch list.

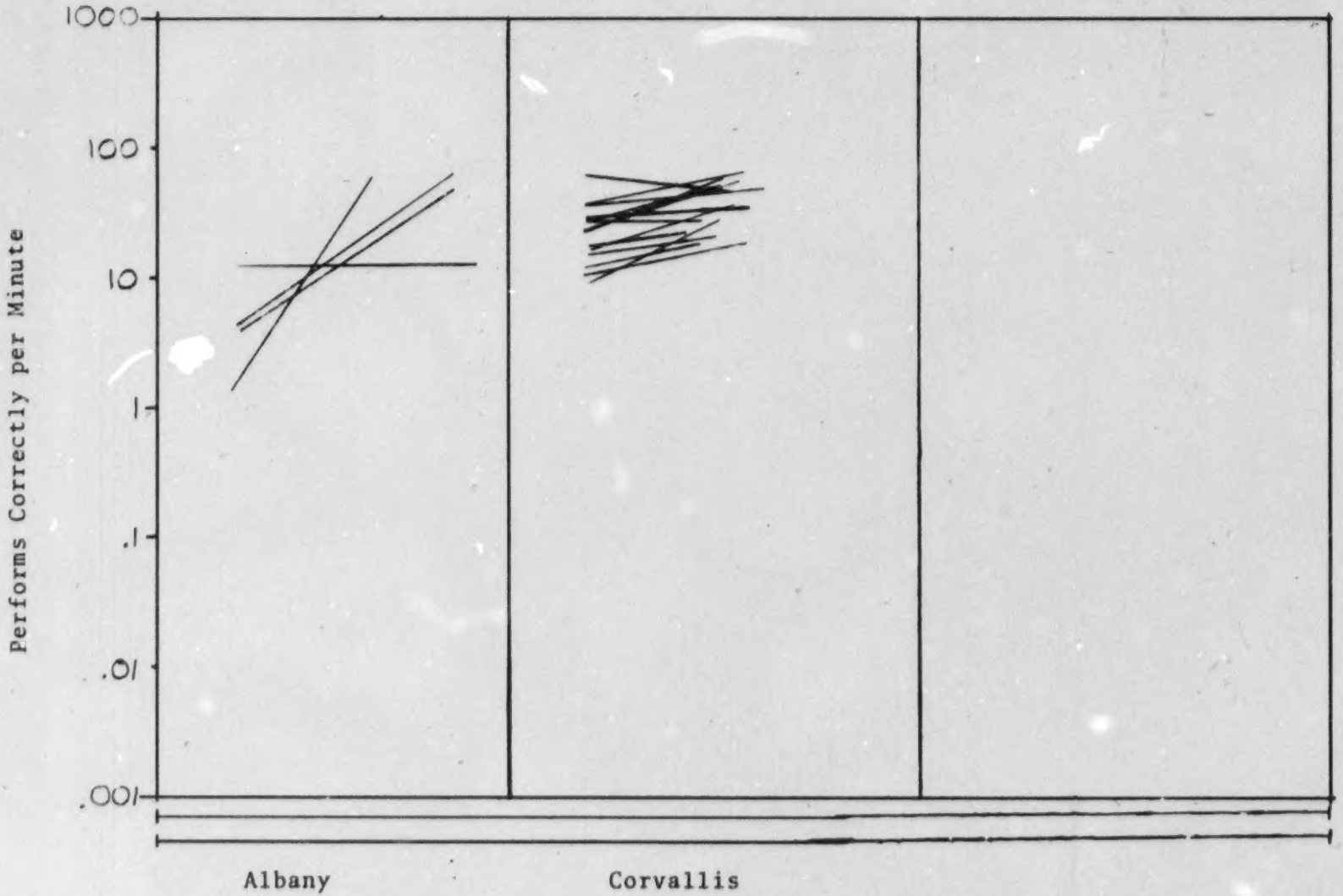


Figure 1. Celerations for Acceleration Projects

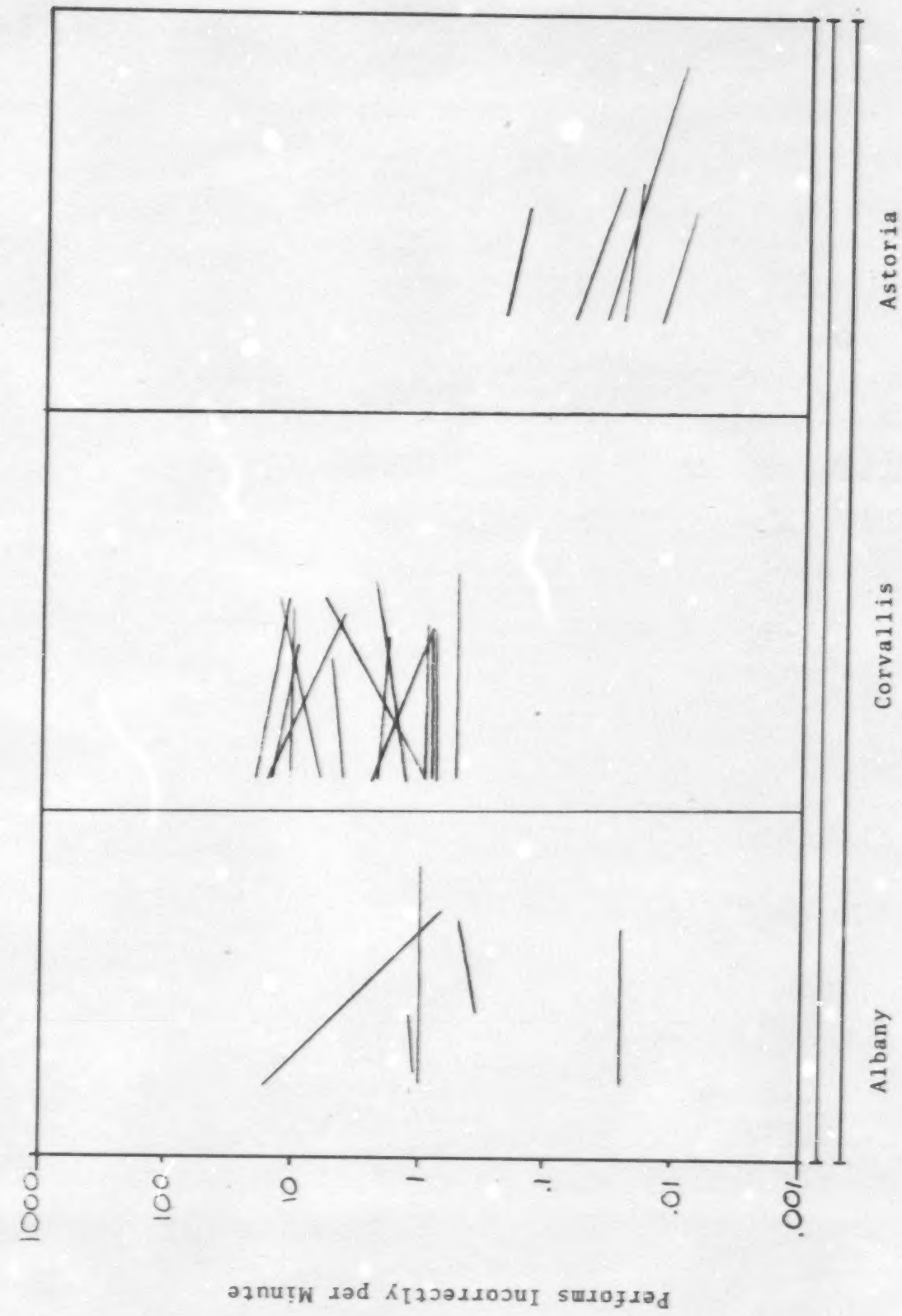


Figure 2. Celerations for Deceleration Project

Astoria. Astoria submitted counts on deceleration management pinpoints for five of the children evaluated. The median celeration was ÷ 1.4. A phase change on each of the projects was intended but the data was not collected. Even without the phase change, however, the celerations indicate that the rate of change was good.

Standardized Tests

It was intended that all three Pilot Centers would also administer the WRAT at the time of the initial evaluation and again at the end of the school year. This would give pre- and post-test scores on each child which could be compared. This was not done by Corvallis or Astoria, due to a lack of time. Table V gives the Dolch word list and the WRAT scores on three of the children evaluated in Albany. Data on the fourth child was not submitted since he was evaluated in mid-May.

TABLE V

Albany Pre- and Post- Test Scores

Child	Test	Pre-test	Post-test	Gain
1.	WRAT spelling	1.7	2.0	+.3
	math	2.4	3.0	+.6
	reading	3.1	2.7	-.4
	Dolch pre-primer	82%	100%	+18%
	primar	73%	96%	+23%
	first	66%	93%	+27%
	second	45%	72%	+27%
2.	WRAT spelling	1.2	1.9	+.7
	math	1.2	1.4	+.2
	reading	1.8	2.6	+.8
	Dolch pre-primer	38%	95%	+57%
	primer	37%	88%	+51%
	first	56%	83%	+27%
3.	WRAT spelling	1.9	2.4	+.5
	math	1.7	2.2	+.5
	reading	2.6	3.0	+.4
	Dolch pre-primer	83%	100%	+17%
	primer	48%	98%	+50%
	first	78%	100%	+22%
	second	43%	98%	+55%
	third	24%	100%	+76%

It can be noted from these scores that the improvement on the WRAT was not outstanding. Child 2 made good gains in the reading and spelling, however, Children 1 and 3 did not make a month per month gain. Looking at the percentage gains on the Dolch lists and at the celerations from the Albany data however, it can be seen that these children did make gains that are indicative of a strong diagnostic-prescriptive remedial program.

Follow-Up

Teachers and Parents

Astoria was the only center who had follow-up data available on the children evaluated. The primary reason for this is probably that Dick Walker, the person in charge of the Astoria Center, was full-time at that position while Kay Greany and Steve Swenson, of Albany and Corvallis respectively, were part-time with the Pilot Center and part-time with the school district.

A complete copy of the Astoria Pilot Center 1974-75 Report may be found in Appendix C.

The Astoria follow-up included both written and personal contact with the teachers and parents of the children evaluated. The results from 21 of the 28 teachers indicate that the recommendations were helpful, and that positive change occurred in behavior, attitude, and outlook toward school. One-third of the parents responded.

At the end of the year, Astoria also did a follow-up to evaluate the services of the Pilot Center. Teachers indicated they were satisfied with the service, specifically, they had been helped, felt the parents had been helped, felt the recommendations were appropriate and specific, and felt that the follow-up of the children was adequate.

The follow-up in Corvallis consisted of telephone calls to the parents and academic probes on the five children who remained within the Corvallis school district. As mentioned above, the probes indicated that the children were making progress at above

average celerations.

Follow-up information on the children was not available from the parents or teachers in Albany. However, the three teachers submitted evaluations of the Albany Pilot Center indicating that the reports were useful and that changes were made in the individualization of programs and in student behavior.

Summary of the Pilot Centers

Although the evaluation components of the Pilot Centers were more sketchy than desired, the celerations, achievement test results, and follow-ups indicated that positive results were achieved.

There are three major reasons for the evaluation of the Pilot Centers being somewhat incomplete. Since this was the first year the Centers were in operation, more time was spent setting up the Center than evaluating it. Secondly, two of the Centers had part-time directors. Thirdly, classroom and ELP teachers failed to see the relevance to them of collecting daily timed data for the purpose of an evaluation. Follow-through with the appropriate teachers was not frequent or strong enough on the part of the Pilot Center directors or this evaluator.

Objective 7. To develop a training program for administrators of diagnostic-prescriptive centers.

The formal training sessions for the administrators took place in July, 1974 for five days, in August 1974 for three days, and in February 1975 for two days. The evaluation of these training sessions will be discussed following Objective 8.

Dr. Rowland conducted these sessions with the assistance of the Model Center staff. The major topics of discussion have included the location of the Center; the evaluations of the children; communication between all clinicians (the psychologist, the learning disabilities specialist and the speech and language clinicians); the importance and value of follow-up and how to do it; and the evaluation of the program at each center.

Dr. Young discussed the diagnostic and prescriptive aspects of child evaluation. Abigail Calkin presented the outline for the evaluation and the items needed from the Pilot Centers for this. At each of the three workshops, Dr. Rowland spent time with the three administrators as a group discussing points relevant to administration. He has also made one trip to each center to discuss administrative roles.

During the 1974-75 year, there were 46 districts within the state requesting to be considered for a Satellite Center site. The eleven chosen are listed below according to the service area, the administrator in charge, and the date of the request.

Formal letters of intent to become a Satellite Center

Area		
Coos County	Tom Walker	Oct. 23
Union County) Wallowa County)	Betty Ellis	Nov. 7
Deschutes County	Louise Hyatt	Dec. 16
Marion	Alan Olsen	Nov. 13
West Linn	Wilma Heater	Nov. 27
Forest Grove	Miriam McDowell	Oct. 30
Eugene	Don Menefee	Dec. 16
Portland	Ruth Peets	Oct. 30
Curry County	Lester Wheeler	Dec. 6
Morrow) Umatilla)	Ernie Christler	N.A.
Harney	Mary Howden	April 21

Figure 3 shows the location of the Model Center and each of the 14 Satellite Centers and the areas which will be served by the Satellite Centers. Figure 4 shows the area which will continue to be served by the Model Center.

Additional training will take place beginning on August 23 for these eleven administrators. The administrators from the Pilot Centers in Albany, Astoria, and Corvallis will also attend.

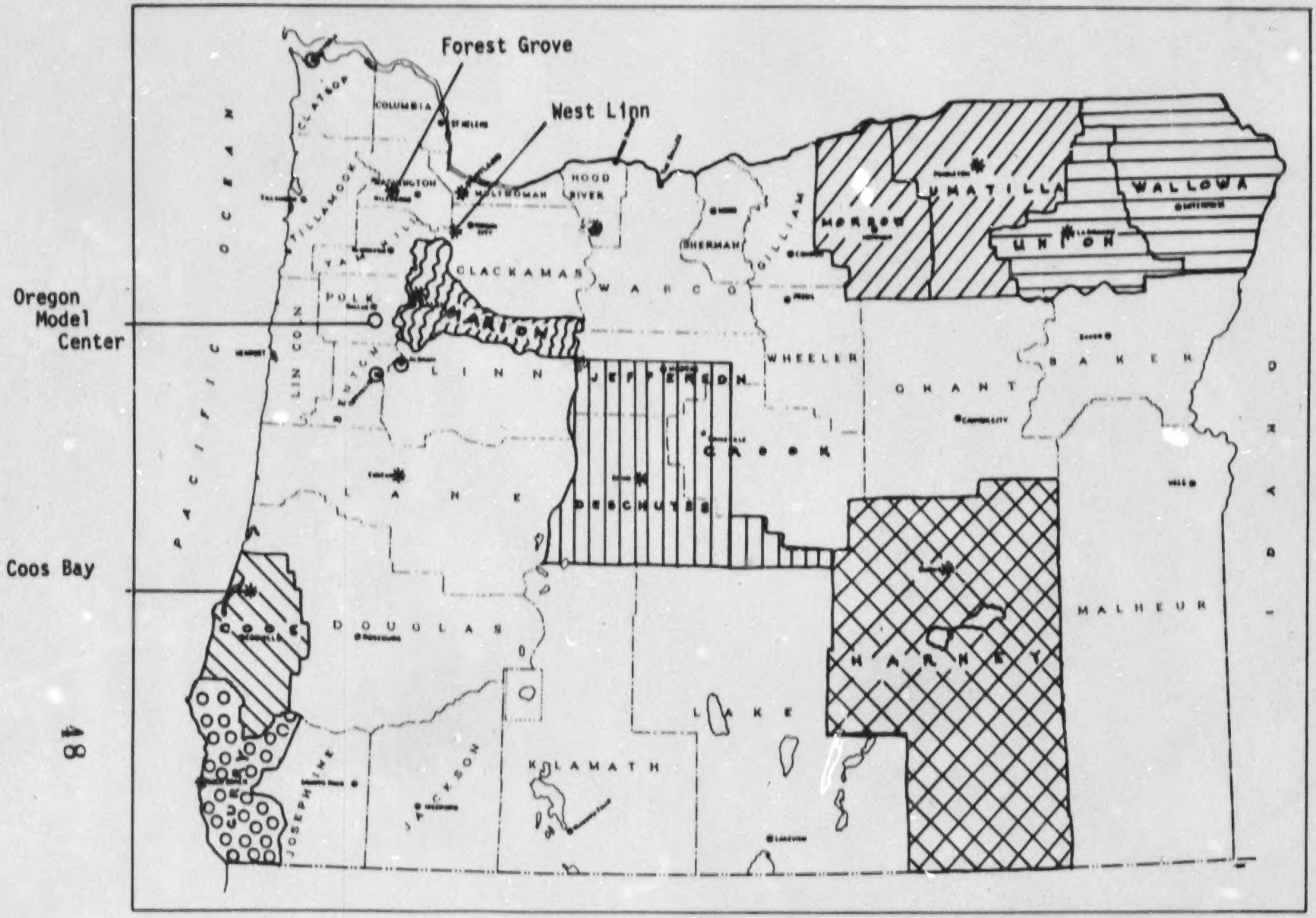
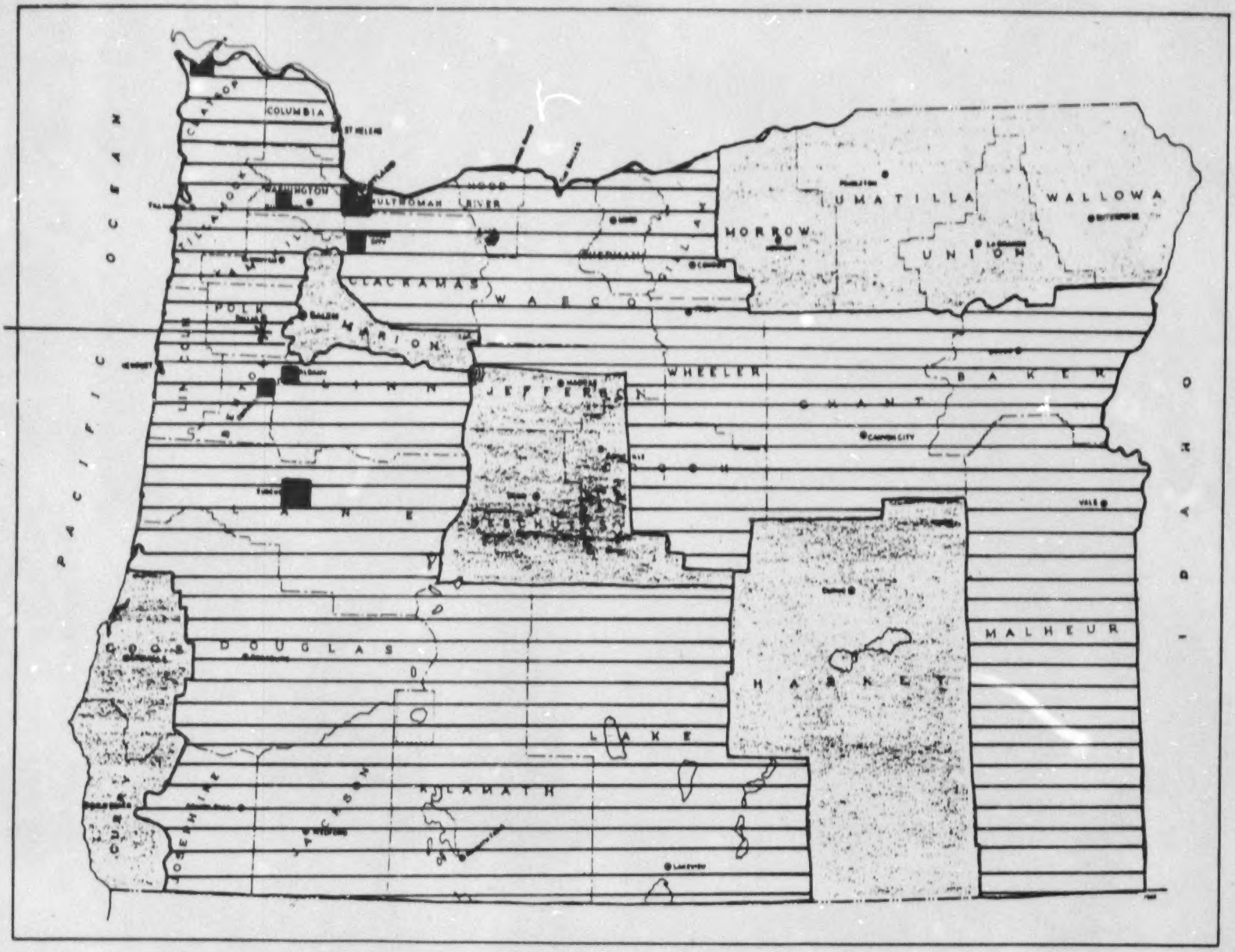


Figure 3. Satellite Centers, 1974-1977.

○ OMC + Pilot Centers 1974-75
✱ Satellite Centers for 1975-77



Area served by Satellite Centers

Direct Services to children by OMC 1976-1977

Figure 4. OMC Service Areas 1975-1977.

Objective 8. To develop a training program for clinicians in Diagnostic-Prescriptive Centers.

The training for the clinicians took place in July 1974 for five days, in August 1974 for three days, and in February 1975 for two days. There were 18 people present at the August 1974 and February 1975 meetings although the same people were not necessarily at both. There will be at least 33 persons present at the August 1975 meeting, some of whom will have the joint role of administrators of the center.

The major items discussed at each of these meetings included the educational assessment, communication with other diagnostic personnel, how to assess speech and language problems, materials prescription, and the evaluation of the assessment process.

Evaluation of Training Sessions

The training sessions for the administrators and the clinicians of the Pilot Centers were evaluated jointly. A pre- and post-test was designed to test content areas of the two 1974 summer training sessions. During the February 1975 training session, each person present wrote a subjective evaluation of all the training sessions he had attended.

At the July and the August training sessions a questionnaire of 50 true-false items was administered (see Appendix D). The mean of correct responses on the pre-test was 31.5; on the post-test the mean was 35.2 correct responses. The significance of the difference between the means of the pre- and post-test scores

on this test was calculated using a 't' test for correlated means. The resulting 't' was 4.80 which is significant at the .05 level of confidence. This indicates that there was a significant increase in the mean scores on this test.

On the pre-test over half the trainees missed 18 items; on the post-test over half missed 11 of the 50 items. Nine of these items missed on the post-test were items also missed on the pre-test. They were item numbers 9, 16, 27, 28, 29, 34, 42, 44, 45, 46, 47, and 50. Possible explanations include that the material was not sufficiently covered in the sessions, that some items did not test material which was taught, that the order of the items should be varied to ensure that fatigue or boredom was not a factor in missing items at the end of the test. These possibilities have been discussed with the Director for revisions of evaluation questionnaires used at future training sessions.

The subjective evaluations submitted in February 1975 were rated according to the number of positive statements, negative statements, and suggestions within each evaluation. Seventy-five percent of the remarks were positive, 10% were critical, and 15% of the remarks were suggestions. Per capita, the three directors had the greatest number of positive remarks and suggestions and the least amount of negative remarks.

Summary

This evaluation has indicated that all of the objectives except two have been completed. Of the two not completed one (The Administrators Manual) will be completed within two months and the other one (the evaluation of both the manuals) will be completed during the 76-77 school year.

The evaluation of Objectives 1 and 2 over the past two years have resulted in positive changes for the Model Center. The evaluation of objectives 2 and 6 have indicated that most children made positive changes. Objectives 3 and 5 have produced some good materials which will be field tested next year. The evaluation of Objectives 7 and 8 indicated that some changes may be necessary in conveying the content of the training sessions.

APPENDIX A

Parent and Teacher

Follow-up Forms

EDUCATION EVALUATION CENTER
LEARNING DISABILITIES

Oregon College of Education
Monmouth, Oregon 96361

Child:
Parents:
Teacher:
School:

SCHOOL FOLLOW-UP EVALUATION

1. Did you receive a copy of the report? Yes ( ) No ( )
   Where is the report filed?

2. What questions or comments do you have about the report?

3. What new insights or information about the child did you gain from the report?

4. Which of the academic, behavior, or social recommendations have you tried with the child at school?

5. As a result of using the recommendations, what changes have you observed in the child?

6. Which recommendations were tried but found not to be helpful? Why?

7. What prevented the implementation of other recommendations? (methods? Materials? other?)

8. Have any formal tests been given recently to support that the child has made academic growth? What were the results?

9. What evidence do you have that the report has been helpful to the child's parents?

10. What further questions or recommendations do you have for the Education Evaluation Center?

(use other side as needed in responding to the above questions)

Child:
Parents:
Teacher:
School :

Education Evaluation Center
Learning Disabilities

Oregon College of Education
Monmouth, Oregon 97361

PARENT FOLLOW-UP EVALUATION

1. Did you receive a copy of the report? Yes ( ) No ( )

2. What questions or comments do you have about the report?

3. What new insights or information about your child did you gain from the report?

4. Which of the academic, behavior, or social recommendations have you tried with your child in your home?

5. As a result of using the recommendations, what changes have you observed in your child?

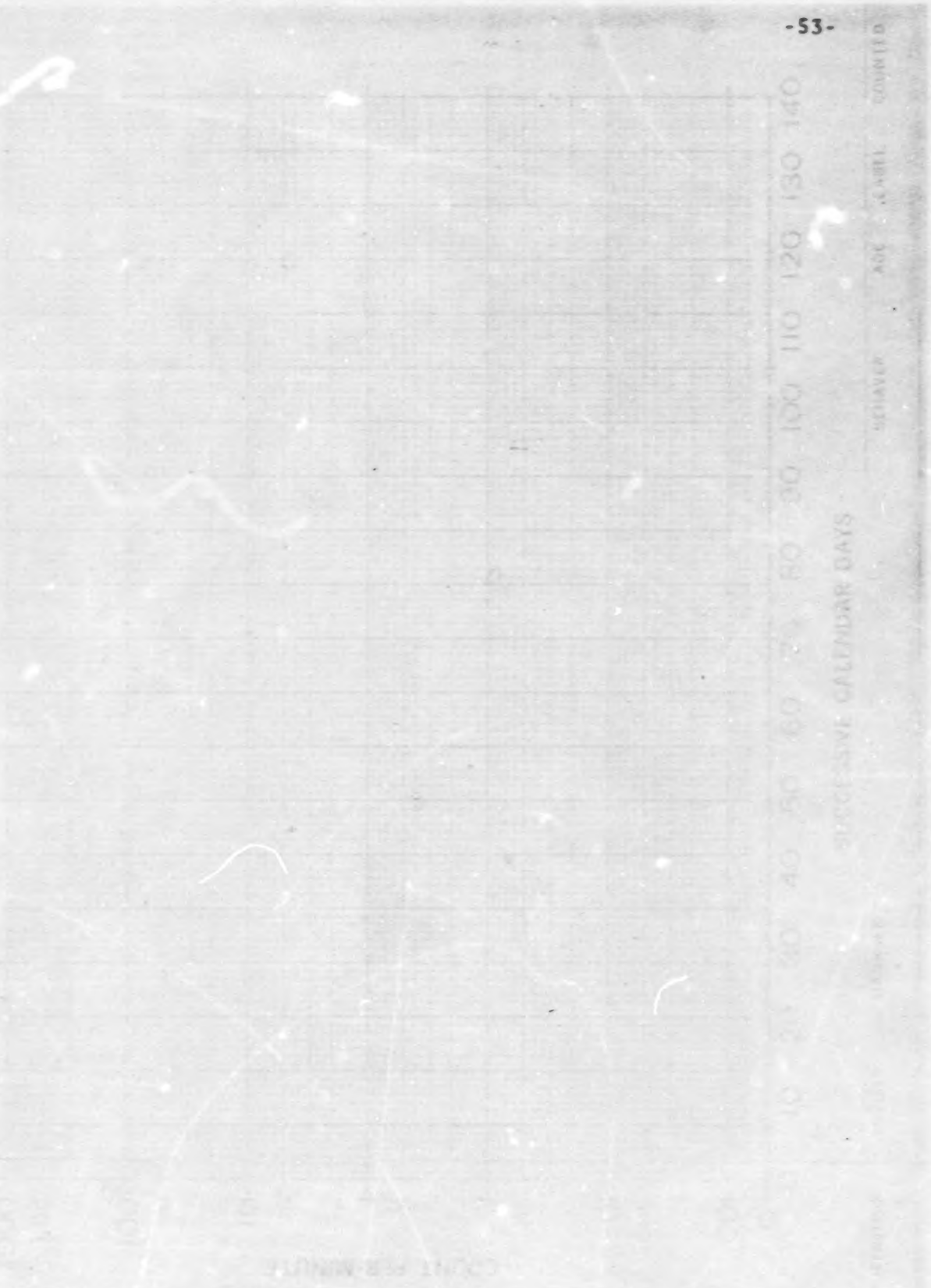
6. Which recommendations were tried but found not to be helpful? Why?

7. What evidence do you have that the report has been helpful to your child's teacher(s)?

8. What further questions or recommendations do you have for the Evaluation Center?

(Use other side as needed in responding to the above questions.)

APPENDIX B


10 20 30 40 50 60 70 80 90 100 110 120 130 140
SUCCESSIVE CALENDAR DAYS
SQUARE AGE LEVEL COUNTED

APPENDIX C

Astoria School District No. 1 C

3196 MARINE DRIVE, P.O. BOX 450
ASTORIA, OREGON 97103
TEL. 325-6441

ROY R. SEEBORG, SUPERINTENDENT-CLERK
JOHN M. McRAE, DIR. OF INSTRUCTION
LORAN R. MATHEWS, BUS. MGR.

June 4, 1975

DIAGNOSTIC-PRESCRIPTIVE SERVICE PROGRAM REPORT FOR 1974-75

Introduction

The Diagnostic-Prescriptive Service Program exists for the purpose of offering specific and concentrated help to those children who are experiencing learning difficulties in regular classroom programs. Our objective is to identify children with educational problems, diagnose possible causes of those problems, and to prescribe and recommend courses of action which will provide the child with his best possible chance for success in school. Because we want the service to help prevent severe school difficulties at later ages, most of our efforts this year have been directed toward helping children in the elementary schools. There has been, however, some limited involvement at the junior high and high school levels.

Preparation

Our association with Oregon College of Education provided us with a good start towards a successful first year. Besides suggesting various forms and procedures we might use, OCE also made available to our program coordinator a number of training sessions on the campus at Monmouth. These sessions were attended as follows:

July, 1974 - 5-day workshop - O.C.E.
August, 1974 - 3-day workshop - O.C.E.
February, 1975 - 2-day workshop - O.C.E.

The workshops covered all phases of the operation of an education evaluation center.

In addition, through October and November, O.C.E. arranged for actual observation on a once-a-week basis of their work with children in theor own on-campus clinic. Dr. Tom Rowland and Dr. Bonnie YOung were responsible for making all this possible. Ken Kosko and Abigail Calkin have also given us their able assistance.

In-district preparations through the September-October period included the following:

Revision of printed forms as required.
Refinement of written referral procedures.
Development of information sheets on diagnostic service.
Building meetings to acquaint staff with D-P service.
Meetings with teachers of children evaluated in the spring of 1974.
Meetings with ELP teachers to discuss their role in program.
Contact with various community agencies which assist us.
Contact with parents of children evaluated in spring, 1974.

These activities subsequently led to additional referrals being made to our diagnostic team.

The Team
Staff team members for 1974-75 have been:

District Personnel:
Classroom teachers making referrals
Building principals
Reading specialists in the buildings
Program coordinator - Dick Walker

IED Speech Pathologists:
Dolores Sharp
Donna Mary Dulcich
Lenore Uchimura

School Nurses:
Barbara Engbretson
Sharon Vaughn

Psychologists:
Ed Bock, Mental Health Clinic
Dr. Leif Terdal, Child Development and Rehabilitation Center, University of Oregon Medical School
Dr. Thomas Rowland, Director, Education Evaluation Center, Oregon College of Education

And on occasion -

Social Workers:
Larry Morisette, Director, Children's Services Division
Carol Moore, Case Worker
Glen Chandler, Case Worker
Joan Ryan, Case Worker

While doctors have not sat in as members of the staffing team, family physicians have been contacted and asked to provide pertinent medical information on the children referred.

The diagnostic service depends upon a team approach as the best way to deal with learning problems. Cooperation of various local agencies has been outstanding. The Clatsop County Mental Health Clinic, the local Health Department, the Children's Services Division, and the Clatsop County Intermediate Education District have devoted much time and effort to the support of our program. In addition, the I.E.D. has made direct, financial contributions totaling $3,500 for such items as training conferences, library materials, psychological assessments, and consultant fees.

The district has been fortunate to have had this year the excellent assistance of Dr. Thomas Rowland, Director of the Education Evaluation Clinic at Oregon College of Education, and Dr. Leif Terdal, from the Child Development and Rehabilitation Center of the University of Oregon Medical School. Dr. Rowland

was instrumental in helping us to get our program going, providing many training sessions for our program coordinator (Dick Walker), as well as providing leadership at several staff conferences. Dr. Terdal played a vital part in providing direct staff leadership, and opened lines of communication to the U. of O. Medical School, and to other resource people in the Portland area. The experience gained from our association with both of these men has been invaluable.

Perhaps the most vital element of our team exists in the person of the district's classroom teachers, reading specialists, and building principals. It is they who first identify the children with special needs, and it is they who are asked to implement and carry out the indicated program changes and recommendations. Without their cooperation and commitment, we would have no program.

Another important element of our team are the parents of the children referred. Parents must, of course, consent to have their child referred to our service before we can proceed. Parents are asked to help implement some of the changes we recommend for their child. The information they provide is critical to an accurate and successful evaluation and we are dependent upon their cooperation.

Case Load

The case load of the diagnostic service is generated by means of teacher referral. The load currently consists of referrals as follows:

	Astor	Central	Gray	Total
Spring, 1974	7	2	2	11
1974-75	11	4	5	20

The schedule of staff conferences for the 20 children referred during this school year was as follows:

Staff conferences for two children were held on each date, except for May 1st, which was a second staffing for a child first done in May of 1974 -

November 7
December 5
December 12
December 19
January 23
February 12
February 27
March 13
April 3
April 17
May 1

Current status of the 31 formal referrals is shown below:

	Following Closely	Following Occasionally	Dismissals	Moved
Referred, spring '74	3	6	2	0
Referred, 74-75	10	8	0	2

In addition to the children formally referred and evaluated, the diagnostic service was involved with at least 18 others. Such involvement usually took

the form of conferences with teachers, conferences with parents, and/or testing sessions with the children. All these contacts were for the purpose of trying to improve the child's school performance in some way. Schools involved were:

Astor - 8	Junior High - 3
Central - 3	Senior High - 2
Gray - 2	

Follow-up and Evaluation

Considerable time has gone into follow-up activities in an effort to assure that recommended program changes and courses of action are resulting in the positive kinds of changes desired. Close contact with teachers through personal conference has been preferred. Other types of follow-up activities have included classroom visitation, and individual tutoring and testing. One goal has been to assist teachers as they confront problems in carrying out the recommendations with the child. Where necessary, recommendations have been altered, or additional suggestions made. Follow-up, to a large degree, is dependent upon the information reported back by the teacher.

Follow-up with parents has been by personal conference, telephone, and by written response forms via mail. The first step is usually a home visit for the purpose of delivering a written report, and reviewing what was covered at the earlier staff conference. Thereafter, contact is usually by phone or mail. In some cases parents have been contacted personally following their regularly scheduled school conferences in November and April.

Evaluating the effectiveness of the diagnostic service is no simple matter. It would be nice to say that every child we have seen has been "turned around," and is "cured." Often, however, we may need to be satisfied with even small improvements in a child's performance, remembering that what seems like a small gain to us may have required great effort on the child's part.

Teachers have given us considerable information on how they view the program. A few parents have responded by means of a written follow-up form. Other ideas and comments have come from principals and other staff team members.

As time goes on, achievement test scores, and special reading scores, of the students will provide information on how much we have been able to help. The following pages represent an attempt to summarize the views and opinions of those involved with the service.

Diagnostic-Prescriptive Report - 1974-75
Page Five
June 4, 1975

Teacher Response

Teachers were asked to complete a follow-up form for each child referred. The following information was obtained from teachers who had referred children to the diagnostic service. Twenty-one teachers responded in time to be included in the following tabulation. Six forms remain outstanding at this time.

1. How many of the recommendations made to the school have you been able to implement? ALL - 10 MOST - 3 SOME - 5 NONE - 2

2. Have you found the recommendations to be helpful to you in working with the child? YES - 17 NO - 1 QUALIFIED RESPONSE - 2

3. Have you observed any changes in the child since our staff conference took place? YES - 17 NO - 5

4. What kind of changes have you observed? (Check all that apply)
   BEHAVIOR - 11 ACADEMIC - 11
   ATTITUDE - 10 OTHER - 0

5. Would you say the observed changes have been: POSITIVE - 19 NEGATIVE - 2

6. In your judgment, to what degree has this child been helped as a result of the referral to our diagnostic program? A GREAT DEAL - 4 VERY LITTLE - 4
   SOMEWHAT - 12 NOT AT ALL - 0

7. As a classroom teacher, what kind of help or service do you want from the Diagnostic-Prescriptive Service Program that you are not now getting? (Sample responses)
   More concrete recommendations (mentioned 3 times).
   Specific recommendations for classroom use with the group--as opposed to individuals.
   Many recommendations need to be carried out by someone other than the classroom teacher.
   You need a counselor to whom some cases should be referred.
   Help for kids who are academically fine, but whose conduct, peer relationship, and feelings about self and others is poor.

8. Specifically, which recommendations have been most helpful to you? (Sample Responses)
   Provided constant positive feedback.
   Explain reasons for things to the child.
   Provide immediate reinforcement and feedback.
   Give specific, individual directions to child.
   Use his other interests to promote interest in reading.
   Provide shorter work assignments for him.
   Use the kinesthetic approach to teaching reading.
   "Back off" to easier lessons and materials for him.
   Recommendations for short, regular homework assignments and individual help.
   Looking for and accepting any positive change, no matter how small.
   Staying in close proximity while giving directions and getting him started.

Giving extra dose of praise.
Accepting limitations and cutting down the workload.
Letting him know mistakes are natural and we learn from them.
Working on the child's self esteem as opposed to academics.

9. Which recommendations have been last helpful? (Sample responses.)
Keeping a written log of events surrounding periods of difficulty.
The suggestion to cut down the tutoring time to reduce his dependency on others.
Relating academics to his practical experiences.
Having other kids help him with his work.
Contracting with the child.
Offering rewards for behavior changes.
Providing an obvious and distinct change of pace for him during class sessions.
Keeping written track of the behaviors I tried to change.
Devising situations in which she could be left in charge.
Providing an isolated study situation.

Parent Response

The following information was obtained from parents. About 1/3 of the parents involved in the program returned the written questionnaires sent out. Questions and responses were:

1. How many of the recommendations made to the home have you been able to use? ALL - 7 MOST - 1 SOME - 2 NONE - 1

2. Specifically, which recommendations have been most helpful to you? (Sample responses were:)
Promote self confidence in child.
Use chart to help control grooming and self appearance.
Involve him in games of change with parents.
Games at home to improve school skills.
Emphasize praise and encouragement and enjoyment of tasks.
Give him more privileges at home.
Realization of the problem and the opportunity to act, with guidance.

3. Which recommendations have been least helpful? (Sample responses were:)
Keep a record of events surrounding the problem periods.
Set a time limit on his dinner time to control his talking at table.
Parenting class at Clatsop College.

4. Have you noticed any changes in your child since our staff conference took place? YES - 8 NO - 1

5. What kind of changes have you noticed?
BEHAVIOR - 4
ATTITUDE - 4
OUTLOOK TOWARD SCHOOL - 3
OTHER - personal appearance - 1
adjustment to classmates - 1

6. Would you say the changes have been: POSITIVE - 8 NEGATIVE - 0
NO CHANGE - 2

7. To what degree do you feel your child has been helped as a result of the evaluation by our diagnostic service?
A GREAT DEAL - 1 VERY LITTLE - 1 JUDGMENT WITHHELD - 1
SOMEWHAT - 6 NOT AT ALL - 2

Additional feedback from parents has been obtained through phone conversations or by conference. Generally, parents' comments have been very favorable towards the program, with positive statements far outnumbering negative ones. Brief notes about numerous parent conversations are on file with the program coordinator.

Year-End Evaluations

At year's end, the teachers who were involved with the diagnostic service were asked to respond to the following questions:

1. With regard to the diagnostic service program, as it applies to you and the children you referred, are you: SATISFIED - 19 DISSATISFIED - 0

2. Did the referral accomplish what you had hoped it would? YES - 17
NO - 1 PARTIALLY - 1

3. Do you feel you were helped to deal with the child referred?
YES - 18 NO - 0

4. Do you feel the child's parents were helped as a result of the referral? YES - 13 NO - 1 ? - 6

5. Did you expect more help than you received? YES - 5 NO - 14

6. Did the recommendations apply to appropriate areas of concern?
YES - 19 NO - 0

7. Were the recommendations specific enough? YES - 18 NO - 1

8. Do you want or need more recommendations in the areas of teaching materials and methods? YES - 4 NO - 10 IT DEPENDS ON THE CASE - 5

9. Was follow-up adequate? YES - 16 NO - 2 ? - 1

10. What type of follow-up is best? BRIEF, UNSCHEDULED CONFERENCES WITH TEACHER-13
CONFERENCES SCHEDULED FOR A SPECIFIC TIME - 7
WRITTEN, QUESTIONNAIRE-TYPE FORMS - 2

11. How can we improve the service of the diagnostic-prescriptive service program? (Sample responses:)
Give bigger range of recommendations.
Provide specialist for one-to-one therapy in some cases.
Improve follow-ups (no further explanation).
Give specific lists of do's and don'ts for teacher to follow.
Write recommendations plainly--don't be afraid of offending someone.

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A series of meetings and conversations were held with staff team members. Following are some of the suggestions and comments which have been made.

From principals:

- Perhaps we need more speech time so that the diagnostic service doesn't draw the therapist too much away from the regular speech program in the school.
- Should develop more specific guidelines for teachers to use in deciding who should be referred to the program. What kind of kid do they refer? How do they pick him out?
- Keep better control of the time element at staffings.
- Maybe a smaller group should meet with the parents during that part of the conference.
- Schedule conferences at the individual schools involved.

From teachers:

- Suggested that recommendations be written on a "cover sheet" rather than being placed at the end of the written report.
- They seem to want quite a few recommendations to choose from, with an indication of which ones the staff team considers the most essential.
- Suggested that the follow-up include a planned, second conference with parents. This might be after about six weeks has elapsed, and would be held at school with just school personnel present.
- Would like a screening test for use with whole class. Should be brief, but helpful in pinpointing children with possible learning problems. (Slingerland?)

From nurses:

- Maybe we need to do more frequent classroom observation in order to give more feedback to teachers, especially regarding reacting positively to kids.
- Might contact the Society for Prevention of Blindness re: vision screening guidelines.
- On written follow-up forms: maybe use questions that are more open-ended.

From Mental Health Clinic:

- School personnel should perhaps administer Wide Range Achievement Test next year and clinic would then have time to get another measure of visual-motor skills, etc.
- Perhaps a behavior checklist could be used with parents to get a before and after measure of behavior.
- Regarding parent follow-up: perhaps a written follow-up procedure might be built into the written reports on a case-to-case basis.

From speech pathologists:

- Need to coordinate who gives what language tests to avoid overlap.
- Incorporate Wepman's new visual descrimination tests as part of the evaluations.

The following data was requested by Oregon College of Education as part of their evaluation of the pilot centers they helped to establish.

Parent Contacts	No. of Parents	No. of Contacts[1]
Children referred spring, 1974	11	36
Children referred 1974-75	21	117
Children not formally referred	10	17

Teacher Contacts	No. of Teachers	No. of Contacts[2]
Children referred spring, 1974	11	50
Children referred 1974-75	23	137
Children not formally referred	17	37

Recommendations

Looking ahead to 1975-76, it would seem that program improvements might be made in several ways. These suggestions are the result of year-end discussions with teachers, principals, consultants, and other staff team members. The suggestions listed below are in no particular order of importance:

1. Offer teachers more assistance in identifying children with potential learning difficulties through development of a guide sheet listing some of the warning signs to watch for.

2. Develop a specific, written follow-up procedure to be used with all future referrals. Procedure should include:

   a. Use of a tickler file.
   b. A second, follow-up parent conference at the child's school after a specified period of time.

3. Incorporate classroom observation as a routine part of the referral process, as well as of the follow-up process.

4. Assume the responsibility of administering the Wide Range Achievement Test to children referred, (formerly done by the Mental Health Clinic), using a pre-test, post-test format to help measure a child's gains.

5. Continue to concentrate on making recommendations as specific as possible--especially those made to teachers.

6. Set down in writing the specific methods to be used in evaluating progress of children referred.

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[1]Parent contacts include at least 2, and usually 3, person-to-person contacts. Other contacts are by phone or letter.

[2]Teacher contacts are usually person-to-person. A few are by printed form (written follow-ups, etc).

DW:mks

report by: Dick Walker
Program Coordinator

APPENDIX D

T F 1. The evaluation center should be located in the child's school building

T F 2. It is better to have one staff member do all the evaluation for one child.

T F 3. Behavior modification is the prescription for 90% of the cases.

T F 4. The Peabody test yields an oral vocabulary score.

T F 5. If spelling is reported to be 4th grade ability, but reading is PP, one should suspect the spelling score to be inaccurate.

T F 6. All children must learn phonics in order to read.

T F 7. A child may fail all the Croft word analysis objective tests (that are expected to be learned by 3rd grade) and still read 4th grade material with 100% comprehension.

T F 8. If a Spanish speaking child misses 15 pairs on the Wepman Test of Auditory Discrimination he may be characterized as having normal auditory discrimination ability.

T F 9. A hearing loss or a poor auditory discrimination score means that phonics should not be prescribed as a method of reading.

T F 10. The WRAT is an accurate predictor of the instructional reading level.

T F 11. Informal reading inventories or oral reading tests will yield approximately the same grade level score for the same child.

T F 12. The examiner should leave the child alone in the room while the child is working his math problems.

T F 13. Auditory figure-ground ability is measured by the audiometric pure tone test.

T F 14. An estimated language age is of little value in most extreme learning problem cases.

T F 15. The child's syntactical ability correlates highly with his level of comprehension in reading and/or hearing capacity.

T F 16. Morphological ability may be assessed from the Peabody Picture Vocabulary Test.

T F 17. The Gates-McKillop oral reading test accurately assesses the grade level of reading ability.

T F 18. The child's method of word attack should determine which oral reading test the examiner will use.

T F 19. The Gray Oral Test will yield similar scores to the Durrell Oral reading test.

T F 20. A child's reader is Sullivan Programmed Reading. Scores from the Gates McGinitie place the child at 3rd grade reading level. This is the instructional reading level of the child.

T F 21. A perceptual deficit must be remediated before academic learning may take place.

T F 22. Personality variables such as "flexibility" and "independence" have little to do with the type of reading or math materials you would recommend.

T F 23. An examiner should never act angry or turn away from the child while testing him.

T F 24. An examiner should not bribe the child with money or candy during the testing or teaching.

T F 25. The materials recommended should be decided upon solely on the basis of the skills the child needs to learn and the grade level of the material.

T F 26. There is a high positive correlation between visual acuity and reading ability.

T F 27. There is a high positive correlation between a test of reality and learning ability.

T F 28. The development of visual motor skills as one might find in Frostig's work enhances academic learning.

T F 29. Eye dominance is over-rated as a cause of learning problems.

T F 30. There is ample evidence that abnormal EEG's pinpoint the cause of some learning problems.

T F 31. As long as one can reduce the learning disability of a child the cause of the problem isn't important.

T F 32. It is far more efficient to evaluate and remediate a problem of a child without involving the parents.

T F 33. One can tell a great deal about the personality of a child by the use of only the WISC subtest scaled scores.

T F 34. The terminal interview (after the evaluation) with the parents is very helpful to the parents in behalf of the children's learning problem.

T F 35. Parents can usually help a neighbor child with his academic skills better than they could their own child.

T F 36. A group test result can be more valuable than an individual test finding.

T F 37. Some authorities do not consider children whose academic level is low but whose intelligence appears to be normal as learning disabled if they are from a different culture.

T F 38. Perception is simply relating a current sensory experience with past experiences.

T F 39. There isn't such a thing as a culture free test.

T F 40. There is no evidence that learning diabilities are inherited.

T F 41. The Benton, The Beery, and the Bender measure the same abilities.

T F 42. The Michigan Tracking Program and Sound, Order, Sense may be used to remedy the same learning abilities.

T F 43. The PMRS or Gilliland's book are sources of prescriptive materials.

T F 44. The ITPA subtest test, memory for digits, yields the same information as the WISC digit span.

T F 45. GOAL, or reactions on a referral form may yield the same information as an ITPA.

T F 46. The Wepman test assesses only auditory discrimination.

T F 47. The WISC vocabulary yields an assessment of word knowledge.

T F 48. Nutrition has little causal effect on a child's learning ability.

T F 49. A child's ability to read is related to his gross and fine motor skills.

T F 50. Hyperactivity is of a neurological/organic origin.